



CLOSE THE GAP

Solutions to the Indigenous Health Crisis facing Australia

A POLICY BRIEFING PAPER FROM THE NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION AND OXFAM AUSTRALIA

APRIL 2007

"The statistics of infant and perinatal mortality are our babies and children who die in our arms...The statistics of shortened life expectancy are our mothers and fathers, uncles, aunties and elders who live diminished lives and die before their gifts of knowledge and experience are passed on. We die silently under these statistics..."

Professor Mick Dodson.

Quoted from the Human Rights and Equal Opportunity Commission's Social Justice Report 2005



 **Oxfam**
Australia

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EXECUTIVE SUMMARY

This briefing paper provides solutions towards solving the health crisis facing Aboriginal and Torres Strait Islanders. It draws on published data and the expertise of the National Aboriginal Controlled Community Health Organisation.

A comparative analysis of national health data for Indigenous populations in Australia, New Zealand, Canada and the United States of America (USA) finds that Australia ranks bottom in the league table of first-world nations working to improve the health and life expectancy of Indigenous people. The key health indicators make it plain:

- Aboriginal and Torres Strait Islanders die nearly 20 years younger than non-Indigenous Australians. This is in stark contrast to the USA, Canada and New Zealand where the life expectancy for Indigenous people is approximately seven years less than the non-Indigenous population
- Aboriginal and Torres Strait Islander infant mortality is three times the rate of non-Indigenous Australians and more than 50 per cent higher than for Indigenous children in the USA and New Zealand

These health indicators are not only a national scandal: they are an international scandal when compared to recent health advances in Indigenous populations in other first-world countries.

This paper argues that the poor health in Australia's Aboriginal and Torres Strait Islander population is preventable. Many of the poor health outcomes for Aboriginal and Torres Strait Islanders are related to social and economic factors: diseases triggered by poverty; overcrowded housing; poor sanitation; lack of access to education; poor access to medical care for accurate diagnosis and treatment; and poor nutrition.

A well planned allocation of human resources linked with an increased investment in health infrastructure, including primary healthcare, as well as adequate housing and the promotion of healthy lifestyles can contribute to health equality between Aboriginal and Torres Strait Islanders and non-Indigenous Australians.

The increase in investment required is modest. The paper cites evidence from the National Aboriginal Community Controlled Health Organisation showing that increased funding for Aboriginal and Torres Strait Islander health services is needed in the range of \$350 – \$500 million per annum. Evidence suggests this additional funding will deliver positive outcomes, the paper citing several examples of pioneering health interventions in Aboriginal and Torres Strait Islander communities that have resulted in significant, sustained improvements in their health.

At minimum, achieving health equality for Aboriginal and Torres Strait Islander health within 25 years will require federal, state and territory leaders from all sides of politics to commit to an agreed time frame for achieving health equality. Additionally, specific measures should be funded:

1. Improved access for Aboriginal peoples and Torres Strait Islanders to culturally appropriate primary health care, and to a level commensurate with need
2. Increasing the number of health practitioners working within Aboriginal health settings, and further development and training of the Indigenous health workforce
3. Improving the responsiveness of mainstream health services and programs to Aboriginal peoples and Torres Strait Islander health needs
4. Greater targeting of maternal and child health and greater support for Indigenous-specific population programs for chronic and communicable disease
5. Greater funding and support for the building blocks of good health such as awareness and availability of nutrition, physical activity, fresh food, healthy lifestyles, and adequate housing
6. Setting national targets and benchmarks towards achieving healthy equality, by which progress can be closely monitored

1. INTRODUCTION

An analysis of national health information gives a powerful insight into the ongoing legacy of colonisation on the Aboriginal people of Australia, New Zealand, Canada and the United States of America (USA).

While these first-world nations boast first class health systems, the key health indicators clearly show that their Indigenous people do not share equally in the benefits from these systems.

Social injustice is largely responsible for the disparity in outcomes that sees Indigenous people suffer a far greater health burden than non-Indigenous people. In Australia, Aboriginal and Torres Strait Islanders experience lower levels of access to health services than the general population, in some part due to residing further from health services, and also as a result of poorer socio-economic status, lack of availability of transport and inability to speak English.¹ Of great concern is that despite widespread acknowledgement of the gap and actions to address it, progress appears to be minimal in Australia.

This briefing paper draws on an academic literature review that considered published peer-reviewed and government accounts of health outcomes for Aboriginal people over the last decade. It focuses on the Aboriginal people of Australia, New Zealand, Canada and the USA. The review: 'Indigenous Health – International Comparative Research' was conducted by Dr Jane Freemantle, Dr Kirsty Officer, and Mr Daniel McAullay at the Telethon Institute for Child Health Research, Centre for Child Health, University of Western Australia.

More than 2,500 papers and reports were discovered through the literature search. Of these, 530 were considered for inclusion in the literature review. The number of papers identified for the specific topics were mortality, 31; injury, 28; cardiovascular, 32; infection, 93; respiratory, 26; rheumatic heart disease, 23; suicide, 31; mental health, 43; diabetes, 32; renal, 37; HIV, 27; sexually transmitted diseases, 22; and health status, 105.²

This paper provides solutions being urged by the National Aboriginal Community Controlled Health Organisation (NACCHO) so that health equality can be achieved within 25 years – a challenge laid down to Australia by the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma.³ Finally – and perhaps most instructively – the paper contains success stories about organisations that are having an impact in improving Aboriginal and Torres Strait Islander health.



Photo: Wayne Quilliam/OxfamAUS

2. INDIGENOUS HEALTH: AN INTERNATIONAL COMPARISON

KEY INDICATORS

Disparities exist in reported life expectancy in the four countries between Aboriginal and non-Aboriginal people. However, the highest disparity between Aboriginal and non-Aboriginal people and the lowest life expectancy has been reported in Australia for Aboriginal and Torres Strait Islander peoples. The adult mortality rate has not improved significantly over the past decades and is now six to eight times that of the total population.⁴ Aboriginal and Torres Strait Islanders have a life expectancy of approximately 20 years less than non-Indigenous Australians.

Chronic conditions including heart disease, stroke, diabetes and renal failure represent a serious and escalating health burden for the Aboriginal and Torres Strait Islander populations in Australia. The incidence of chronic disease is much more common in Aboriginal and Torres Strait Islanders compared with non-Indigenous Australians and it occurs at a much younger age. Major contributing factors are persistent social and economic disadvantage coupled with poor access to health care and poor nutrition.

The slow rate of improvement in health and increase in mortality in Australia is in stark contrast to the most recent trends in New Zealand, Canada and the USA where life expectancy gaps have been reduced to three and seven years respectively.⁵

Life expectancy was similar for New Zealand's Maori people (69 years) and for First Nations people of Canada (68.9 years) and lowest for Australian Aboriginal and Torres Strait Islander males (56 years). The life expectancy of Indigenous females was highest for Canadian First Nations females (76.6 years) and lowest for Aboriginal and Torres Strait Islander females (63 years).⁶ (See Table 1. overleaf)

These figures reinforce the finding of the United Nations Human Development Report from 2003, the proportion of Aboriginal and Torres Strait Islander Australians expected to live to age 65 is lower than underdeveloped nations like Bangladesh and Nigeria.⁷

Infant mortality differences between Indigenous and non-Indigenous populations

Infant mortality is also higher and the disparity greater among Aboriginal and Torres Strait Islanders than the rates reported in New Zealand, Canada and the USA. The latest statistics on child mortality show Aboriginal and Torres Strait Islander children are almost five times as likely to die before the age of five as non-Indigenous children.⁸ Infant mortality has improved since the 1970s but is still over three times that of the total Australian population.⁹

Mortality in the early years, particularly in the first year of life, is an important measure of the effectiveness and availability of health services for mothers and children. The data on infant mortality is relatively accurate because it comes from the one data set. Consequently disparities in infant mortality rates between rich and poor nations and between Aboriginal and non-Aboriginal children are important and relatively accurate indications of inequalities in social and economic status as well as inequalities in the availability of healthcare.¹⁰

The rate of Indigenous infant mortality was highest among Australian Aboriginal and Torres Strait Islanders (14.3/1,000 live births) and lowest among Canada's First Nations people (6.4/1,000 live births). The relative difference was highest among Australian Aboriginal and Torres Strait Islanders (three-fold) and lowest among First Nations people (1.2). The highest proportion of Indigenous babies born prematurely at less than 31 completed weeks was observed among Australian Aboriginal and Torres Strait Islanders (13 per cent).

(Further comparative information on diseases can be found on pages 17-24.)

TABLE I: Comparing Life expectancy (LE) – Indigenous and non-Indigenous peoples

	Australia*		New Zealand*		Canada*		USA*	
	Aboriginal and Torres Strait Islander	(All)	Māori	(All)	First Nation	(All)	American Indians/ Alaskan natives	(All)
LE (years)								
Males	56	(76.6)	69.0	(76.3)	68.9	(76.3)	67.4	(74.1)
Females	63	(82.0)	73.2	(81.1)	76.6	(81.8)	74.2	(79.5)
Median age	21	(35)	22.0	(33.9)	24.7	(37.7)	27.8	(35.8)
Infant mortality (per 1000 live births)	14.3	(4.7)	8.9	(5.7)	6.4	(5.3)	9.8	(6.8)
Low birth weight (proportion of LBW live births)	13%	(6%)	8%	(6%)	5%	(6%)	6%	(8%)

*Aboriginal compared with (all non-Aboriginal)

SOURCES ¹¹

The table shows:

- Aboriginal and Torres Strait Islanders die nearly 20 years younger than non-Indigenous Australians
- The difference in life expectancy for Indigenous people compared to non-Indigenous people is approximately seven years in the USA and Canada, 7.5 years in New Zealand and nearly 20 years in Australia
- Aboriginal and Torres Strait Islander infant mortality is three times the rate of non-Indigenous Australians. Nearly three times as many Aboriginal and Torres Strait Islander children die before the age of five than Indigenous children in Canada. Infant mortality rates for Aboriginal and Torres Strait Islanders are more than 50 per cent higher than for Indigenous children in the USA and New Zealand
- 13 per cent of Indigenous babies born in Australia are of low birth weight – more than double the incidence of low birth weight babies in Indigenous populations in Canada and the USA; and more than 60 per cent higher than the frequency of low birth weight Indigenous babies born in New Zealand



Photo: Wayne Quilliam/OxfamAUS

3. SOLUTIONS TO THE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH CRISIS

Aboriginal peoples and Torres Strait Islanders have a lower life expectancy than any other first-world country Indigenous population. Put simply, Australia ranks bottom in a league table of first-world wealthy nations working to improve the health and life expectancy of Indigenous people.

The reasons why other nations have been able to make significant strides toward health equality between Indigenous and non-Indigenous people are multifaceted. However, it is clear that political leadership and will have been major factors in achieving health gains and improvements in wellbeing for Indigenous peoples in New Zealand, Canada and the USA beyond what Australia has been able to deliver for its own Indigenous population. It is inconceivable that a country as wealthy as Australia cannot solve a health crisis affecting less than 3% of its population.

Poor health affecting Aboriginal peoples and Torres Strait Islander communities is preventable. As the data shows, most of the diseases leading to premature death, hospitalization and chronic disability are preventable if diagnosed early, and treated with affordable medicines.¹² Also, the onset of a significant proportion of communicable disease could be prevented if overcrowded housing was addressed and health hardware was made available.

A well planned allocation of human resources linked with an increased investment in health infrastructure, including primary healthcare, as well as adequate housing and the promotion of healthy lifestyles can contribute to Aboriginal and Torres Strait Islander health equality with other Australians.

There are clear signs of some improvement in health status – infant mortality rates are continuing to fall, communicable disease mortality is falling, and research shows some improvement in some chronic diseases.¹³ Aboriginal community-controlled health services that are funded to levels required to deliver best practice improve antenatal attendances and reduce low birth weight.¹⁴

These improvements are testament to the fact that change can be made. But as most of the changes to communicable disease prevalence are due to the introduction of specific initiatives such as better vaccines and expanded primary healthcare, the magnitude of these gains would be multiplied significantly if investments *commensurate with need* were made to core primary healthcare services.

Without these investments, the continuation of short-term incremental programs might undermine the gains already made as a new generation of Aboriginal children are born to the continuing influence of adverse health determinants and poor access to primary healthcare (and hence medicines and other treatments).¹⁵

Australians spend \$1.9 billion on confectionery each year. Just one-quarter of this sum, an allocation of an additional \$460 million annually towards culturally appropriate primary healthcare services, could help solve this health crisis if governments followed the recommendation of the Australian Medical Association (AMA).¹⁶ The AMA's proposal of \$460 million in additional funds to bring about primary healthcare equity for the Aboriginal and Torres Strait Islander population is equivalent to a 1 per cent increase in the federal health budget and merely represents the shortfall in current spending when the level of health need is factored.

The National Aboriginal Health Controlled Community Organisation's 2006 budget submission "Initiatives for the 2007/08 Budget Considerations"¹⁷ makes the following important points:

- An additional \$460 million per annum would help fix the shortfalls in primary healthcare funding for Aboriginal and Torres Strait Islander peoples. There have been five estimates of the approximate shortfall in funding for Aboriginal and Torres Strait Islander health services – all five put the shortfall in the range of \$350–\$500 million per annum

- There is every reason to be confident that the additional expenditure and associated programs would produce 30 per cent reduction in mortality in ten years or less – as this has previously occurred in New Zealand, Canada and the USA
- The health sector has an important role to play in encouraging other areas of the government and public service (i.e. ministers and senior public servants in other portfolios) to play a more definitive role in health relating to their areas of responsibility e.g. education and housing
- While there is attention on the significant increases in the Office of Aboriginal Torres Strait Islander Health (OATSIH) budget, Access Economics points out that the OATSIH budget is a relatively small portion of overall expenditure on Aboriginal and Torres Strait Islander health. The crucial shortfall is in the mainstream Medical Benefits Scheme/Pharmaceutical Benefits Scheme programs. Until Aboriginal and Torres Strait Islander peoples get their share of these programs (on a needs basis), the gap in equitable funding will not narrow. (While spending on Aboriginal and Torres Strait Islander health has increased, it hasn't done so any faster than for the rest of the population so the expenditure gap hasn't narrowed.)
- The net effect is that Australia has in effect run a system in which Aboriginal and Torres Strait Islander peoples receive a lesser level of service right across the continuum of care than the rest of the population – less on prevention, less on primary healthcare, less for surgery in hospital and less for rehabilitation. The apparent higher expenditure on hospital care is almost certainly less than it should be on a needs basis, given the higher illness levels
- Spending less on people with worse health is not good national policy. The Federal Government, through programs under its own direct control (i.e. Medical Benefits Scheme/Pharmaceutical Benefits Scheme, OATSIH, aged care but excluding transfer payments to the states), spends approximately 70c per capita on Aboriginal and Torres Strait Islander people for every \$1 spent on the rest of the population

The critical shortfalls are on primary healthcare and prevention and these are the circuit breakers for improving Aboriginal and Torres Strait Islander health. The importance of early intervention in childhood to prevent poor health outcomes in adulthood should not be underestimated. What's needed most of all is a comprehensive national program to improve maternal and child health as a starting point towards improving the health of the next generation of Indigenous Australians. Such programs would aim to improve antenatal and neonatal care, increase birth weight and reduce premature delivery.¹⁸



The Community Development and Employment Program, run by the shire of Mornington Island, provides training and employment opportunities for local men. The men are given training in vocations such as carpentry and horticulture.

Photo: Wayne Quilliam/OxfamAUS

3.1 RECOMMENDATIONS:

WHAT MUST BE DONE BY FEDERAL, STATE and TERRITORY LEADERS

At minimum, achieving health equality for Aboriginal and Torres Strait Islander health within 25 years will require federal, state and territory leaders from all sides of politics to commit to an agreed time frame for achieving health equality.¹⁹

SPECIFIC FUNDING PROPOSALS:

The following specific measures should be funded and examples are outlined below:

1. Improve access for Aboriginal peoples and Torres Strait Islanders to culturally appropriate primary healthcare, and to a level commensurate with need
2. Increase the number of health practitioners working within Aboriginal health settings, and further development and training of the Indigenous health workforce
3. Improve the responsiveness of mainstream health services and programs to Aboriginal peoples and Torres Strait Islander health needs
4. Greater targeting of maternal and child health and greater support for Indigenous-specific population programs for chronic and communicable disease
5. Greater funding and support for the building blocks of good health such as awareness and availability of nutrition, physical activity, fresh food, healthy lifestyles, and adequate housing
6. Set national targets and benchmarks towards achieving healthy equality, by which progress can be closely monitored

These initiatives are in-line with current health policies such as the National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003-2013) which has seen a commitment from state and federal governments.²⁰

1. Improve access for Aboriginal peoples and Torres Strait Islanders to culturally appropriate primary healthcare, and to a level commensurate with need

The need to improve comprehensive primary healthcare commensurate with need has been described as necessitating four times higher per capita spending for Aboriginal-specific primary healthcare services than is currently the case. The cost per capita for Indigenous-specific primary healthcare service delivery should be approaching \$1,300 per capita, compared to the current spending of only \$300 per capita.²¹

According to Access Economics commissioned by the AMA, **the additional cost of providing primary healthcare to the level commensurate with need has been estimated at \$460 million per annum.**²² This is the cost incurred in providing Medicare services to meet the level of health need, to ensure medicines are supplied that are not currently being provided, and to ensure dental services and medical consumables including appliances that cannot currently be accessed.

The relative under-use of Medicare and the PBS by Aboriginal Australians has for many years been termed the “missing millions” by health bureaucrats. The Federal Government should move to ensure these funds are made available to Aboriginal peoples to supplement core primary healthcare immediately. Thus, as Access Economics have stated: “The debate is not about the compass setting, but rather about the speed with which the goals are being pursued”.

Primary healthcare services infrastructure can be funded as an up-front capital cost or financed on a pay-as-you-go basis. Access Economics express this cost as an ongoing annual charge – as a percentage of recurrent costs estimated at 35 per cent. Thus, an estimate of \$120 million per annum would be the annualised cost of the additional infrastructure required by the higher staffing levels.

The effect of increasing funding to core primary healthcare would, over time, reduce the cost of hospital services (both in admissions rates and in utilization of non-admitted services). This would thus partially offset the increased expenditure in primary healthcare.

Funding to this level and additional resourcing for infrastructure would improve the capacity of these services to deliver the core elements of primary healthcare as shown in the table below:

Core primary healthcare delivered by Aboriginal community controlled health services

1. Clinical Services

- Primary clinical care such as treatment of illness using standard treatment protocols, 24 hour emergency care, provision of essential drugs and management of chronic illness
- Population health/preventive care such as immunisation, antenatal care, appropriate screening and early intervention (including adult and child health checks and secondary prevention of complications of chronic disease), and communicable disease control
- Clinical support systems such as pharmaceutical supply system and comprehensive health information system (population registers, patient information recall systems, and systems for quality assurance)

2. Support Services

Internal to the health service

- Staff training and support such as Aboriginal health worker training, cross cultural orientation, continuing education
- Management systems that are adequately resourced, financially accountable and include effective recruitment and termination practices
- Adequate infrastructure at the community level such as staff housing and clinical facilities, and functional transport facilities

External to the health service

- Systems for supporting visiting specialists and allied health professionals (including dental, mental health etc), medical evacuation or ambulance services; access to hospital facilities
- Training role for tertiary and other students

3. Special Programs

Based on locally relevant priorities and the availability of funds for programs directed at rheumatic fever, substance misuse, nutrition, environmental health, particular target groups such as youth, aged and disabled people, young mothers, school children etc.

4. Advocacy and policy development

Support for the community on local, state and federal issues

Sourced from Aboriginal and Medical Services Alliance Northern Territory.

The Federal Government and every state and territory government fully supports culturally appropriate primary healthcare services such as Aboriginal Community Controlled Health Services (ACCHS) for Aboriginal peoples and Torres Strait Islanders. These services are accessible to Aboriginal and Torres Strait Islanders, are substantial providers of comprehensive primary healthcare, are important players in assisting with social change, and are fully supported within Australia. Moreover, these services are delivered within a governance structure that is Aboriginal community-controlled that provides for community participation and a culturally safe operational framework.

2. Increase the number of health practitioners working within Aboriginal health settings, and further development and training of the Indigenous health workforce

There is currently a shortfall of more than 400 doctors, more than 600 nurses and associated shortfalls in numbers of Aboriginal health workers and allied health workers supporting Aboriginal and Torres Strait Islanders health services. Without these staff, services such as core primary healthcare and population programs cannot be optimally delivered. Current recruitment opportunities are hindered by the inability for Aboriginal-specific primary healthcare services to provide competitive salaries and having to compete with the state hospital sector and private sector salaries which are substantially higher.

A ten-year national training plan for Aboriginal and Torres Strait Islander doctors, nurses, dentists, allied health workers, and Aboriginal health workers is needed to bridge the training gap between the Aboriginal and Torres Strait Islander peoples and general populations of Australia, through for example university support units and scholarship programs. **This has been costed at \$36.5 million per annum.**

Training Centres of Excellence in primary healthcare are also needed, with links to hospital care in each state and territory. These will provide service models for teaching and applied research into continuous methods of progressively improving health services and their outcomes. **This has been costed at \$10 million per annum.**

3. Improve the responsiveness of mainstream health services and programs to Aboriginal peoples and Torres Strait Islander health needs

Pharmaceutical Benefits Scheme usage by Aboriginal peoples in remote areas is approximately two times the usage rate of the Aboriginal population in non-remote areas due to the success of initiatives that are only available in remote areas. These initiatives need to be extended to non-remote areas as Aboriginal peoples in these localities access the PBS at less than one quarter of that used by other Australians. Approximately 27 per cent of Aboriginal and Torres Strait Islanders live in remote areas, with the bulk of the population living in non-remote and urban centres.²³

With regard to the PBS, an additional \$85 million per annum that should be spent on Aboriginal peoples is not being spent (this is part of the \$400 million under-spend). Introducing a national scheme so that Aboriginal peoples can access medicines similar to the remote area access scheme is an urgent and long overdue federal priority and has been advocated by NACCHO, the Pharmacy Guild and the AMA. The Guild and NACCHO have developed a national proposal and this should be supported.

Strategies need to be supported to reduce inequities in access for Aboriginal peoples to hospital procedures, population screening programs, cardiac rehabilitation, hearing rehabilitation services and a number of other mainstream programs. This may require realigning the bilateral state agreements so that there is greater commitment to health equity for Aboriginal peoples. There is strong evidence that untied federal grants to the states leads to neglect of Aboriginal peoples, and this situation needs to be corrected.

For all these areas, Aboriginal peoples have less access than other Australians. It is estimated that the cost of addressing the shortfall in **access to cardiac rehabilitation alone is around \$20 million per annum.**

Aboriginal and Torres Strait Islander people also have much less access to specialist services. Such services might be funded through the Medical Benefits Scheme but organized through staff from state and territory health services and with direct links to Aboriginal-specific primary healthcare services. **Support for a specialist access program for Aboriginal peoples has been costed at \$10 million per annum.**

4. Increase targeting of maternal and child health and greater support for Indigenous specific population programs for chronic and communicable disease

There are a number of Aboriginal early childhood programs across the country where services have ceased due to lack of resources. According to the AMA, **funding for culturally appropriate maternal and child health programs within Aboriginal health services across Australia to the level shown to be effective in exemplar sites requires an additional \$20 million per annum** (not including set-up costs).²⁴ (See 'Mums and Babies' project below.)

A national plan for improving the health of Aboriginal and Torres Strait Islander mothers and babies is also lacking.

Additional programs are needed to ensure freedom from hunger (given that growth failure is highly prevalent in Aboriginal children in remote and rural communities) such as through at-risk and school-based programs.

Note that the current 'Healthy for Life' program largely supports quality assurance activities for services delivering maternal and child health and chronic disease, and helps to set the groundwork for primary healthcare systems monitoring for such programs. As such, it is insufficient to boost the provision of primary healthcare to mothers and babies to the degree needed.

Certain chronic and communicable diseases require specific attention because they disproportionately affect Aboriginal peoples. Funded strategies to address these problems are currently lacking and should be developed to supplement core primary healthcare. Examples include national strategies for:

- Problem drinking
- Smoking cessation
- Immunization
- Rheumatic heart disease and rheumatic fever
- Cancer prevention

In total, these strategies have been costed at \$50 million per annum.

5. Increase funding and support for the building blocks of good health such as awareness and availability of nutrition, physical activity, fresh food, healthy lifestyles, and adequate housing

States and territories have “committed in principle to provide resources commensurate with need including effectively resourcing environmental health initiatives to reduce the backlog of essential infrastructure and housing capital and to provide for effective operation and maintenance of health environments.”²⁵ The housing shortfall facing Aboriginal peoples has been estimated at over \$800 million in the Northern Territory alone as reported in 2006.²⁶ **A study commissioned by the Aboriginal and Torres Strait Islander Commission in 1999 estimated the shortfall at \$2.3 billion needed for purchasing and construction of homes and related infrastructure.**

A specific strategy has been developed to enhance the nutrition of Aboriginal peoples, but while states and territories have supported elements of this strategy, it is not rolled-out consistently and in remote locations across Australia the cost of food is still considerably higher than other parts of Australia. The right to be free from hunger is not fully realized in Australia for Aboriginal peoples.

6. Set national targets and benchmarks towards achieving healthy equality, by which progress can be closely monitored

Indicators to assess Aboriginal peoples progress in attaining health improvements have been recently approved by COAG committees.^{27 28} While these are of vital importance they are not linked with benchmarks or targets to be reached within a specified time frame. In the absence of targets and a specified time in which to meet them, it is not possible to hold governments accountable for their obligations towards Aboriginal peoples. Targets can be readily developed for key deliverables and for those where the desired level of performance is evident and agreed.

Targets (and their associated indicators) have been established under the United Nations Millennium Development Goals (MDG) which aim to halve global poverty by 2015 and Australia has pledged to achieve them. It has also been proposed that Australia should develop MDGs for Aboriginal Australians.²⁹

The Aboriginal and Torres Strait Islander Social Justice Commissioner's call for health equality within a generation (25 years) suggests that this time frame should be used in a 'plan for health equality'. In order to reach such a goal, targets for each objective are needed, such as optimizing the capacity and infrastructure of Aboriginal primary healthcare services. Such a target should be reached early and within ten years so that a generation of Aboriginal Australians can start to benefit from these services.

The existing COAG indicators provide the needed tools to monitor progress. In addition, specific 'right to health' indicators to hold 'duty-bearers' to account are recommended by the UN.^{30 31} In other words, it is insufficient to report on vital statistics and other health outcomes alone. The responsiveness of governments to core 'right to health' obligations should also be monitored. Many of the existing COAG indicators would fulfill this role (eg. level of health expenditure compared with need), but others would also be needed to measure progress in meeting agreed targets.

For example, the World Health Organization has developed indicators to measure access to essential drugs. These indicators provide a rapid assessment of government commitment to this core obligation under the right to health.³² In Australia, measuring 'access to medicines' alone, as in the COAG indicators, won't inform on government willingness to act on the existing inequitable supply arrangements. Australia has already developed indicators for medicines use in Australia and these provide the correct template for monitoring such a right to health indicator for Aboriginal peoples.³³

4. ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SUCCESS STORIES

Pioneering health interventions in Aboriginal and Torres Strait Islander communities Australia-wide prove there is reason to be optimistic about the prospect of improving the wellbeing and health of these communities. Well resourced community controlled, culturally appropriate and accessible programs can and do have a positive impact and result in significant, sustained improvement in the health of Aboriginal and Torres Strait Islander peoples.

‘Mums and babies’ project, Queensland

In Townsville, the local Aboriginal and Torres Strait Islander community identified a need for a ‘mums and babies’ clinic. The aim was to provide comprehensive and integrated primary healthcare for young Aboriginal and Torres Strait Islander families. A two-year pilot project began in 2000 which continues to this day.

The centre is run by Townsville Aboriginal and Islander Health Services and is staffed in collaboration with Queensland Health’s child health unit, obstetrics unit (Kirwan Women’s Hospital) and Aboriginal and Islander health program. The clinic is an example of what can be achieved when Indigenous and non-Indigenous communities and their health professionals work together.

The clinic has a young family orientation providing antenatal and postnatal medical examination, pregnancy nutrition and substance use advice. It also provides birthing information and support, supervised childcare, and advice and information for women on staying healthy during pregnancy. The clinic immunizes children against disease, monitors child development and offers a transport service for mothers and their babies to and from the clinic.

Since 2000, the service has received 37,560 patient visits. This has resulted in a marked improvement in the birth weight of babies, an increased mean weight in birth weight and an increased attendance to antenatal care with 60 per cent of Townsville-based Aboriginal and Torres Strait Islander women attending by 2003. For more information visit <http://www.taihs.net.au/>

‘Safe sleeping’ in Aboriginal communities, Western Australia

Aboriginal and Torres Strait Islander infants are eight times more likely to die from Sudden Infant Death Syndrome (SIDS) than non-Indigenous Australians. SIDS & Kids WA, alarmed by the incidence of SIDS and the lack of culturally appropriate SIDS education and resources, is tackling the issue. The agency works with researchers, health workers, health professionals, policy makers and Aboriginal and Torres Strait Islander communities to devise culturally appropriate, community-driven SIDS education programs. Outcomes include introducing ‘safe sleeping’ education to the training curriculum for Aboriginal and Torres Strait Islander health workers and developing a manual to train health professionals working in Aboriginal and Torres Strait Islander communities.

‘Strong Women, Strong Babies’ program, Northern Territory

The ‘Strong Women, Strong Babies’ program, according to Northern Territory Health, is a shining example of what can be achieved when Indigenous and non-Indigenous health professionals work together. Staff at a NT-based centre consult with Aboriginal and Torres Strait Islander women and health workers about poor nutrition and infection during pregnancy. Senior Aboriginal and Torres Strait Islander women are employed to deliver the project in a culturally appropriate manner. They help women prepare for pregnancy and encourage them to visit clinics for antenatal care early in their pregnancy. Promoting safe practices such as abstinence from alcohol and smoking during pregnancy has helped to increase the mean birth weight of Aboriginal and Torres Strait Islander infants by 171g.

The program has been credited by the Australian Medical Association as having a profound effect on improving birth weights as well as the health of mothers and babies and has captured the imagination and participation of the Aboriginal and Torres Strait Islander community.

Nganampa Health Council, South Australia

Nganampa Health Council's primary healthcare service for the Anangu people of far north-west South Australia has a national reputation for best practice clinical services, leading-edge collaborative program research and development, and the collection of outcome data as a basis for ongoing evaluation.

Nganampa Health operates nine clinics in the region, a 16-bed aged care respite facility, and assorted programs including health worker training, substance abuse prevention, and sexual, environmental, dental, women's, men's and children's health programs. The service is staffed by more than 120 people, the majority Anangu residents from the Lands.

The health and wellbeing of the community has improved immeasurably as a result of this primary healthcare service. In 2005, infant birth weights increased dramatically and screening coverage for HIV and sexually transmitted infections (STIs) was the most thorough to date. By August 2005, 99 per cent of children under five, 89 per cent of six to 14 year olds and 77 per cent of 15 to 19 year olds had been immunized for Meningococcal C.

Critical to the service's success is the fact it is controlled, owned and managed by the Anangu people who are responsible for all key policy, resource allocation and staff appointment decisions. The director and clinic managers are Anangu and together they ensure that all staff are accountable to the Anangu people and that Anangu determine the development and delivery of services. For more information visit <http://www.nganampahealth.com.au/>

Caring for women and children, Western Australia

Ngunytju Tjitji Pirni is an incorporated Aboriginal and Torres Strait Islander maternal and infant health service which has been running since 1993. It was developed to address the unacceptably high rates of Aboriginal and Torres Strait Islander maternal and infant death and illness in Western Australia. The service provides a community-owned agency staffed by Aboriginal and Torres Strait Islander health workers using culturally appropriate methods and resources delivered to women and children in their home environments.

Ngunytju Tjitji Pirni strives to improve the state of Aboriginal and Torres Strait Islander health in the Goldfields region by improving the health of mothers – making them better able to care for their families – and the health of their babies so they may expect longer, healthier lives. Health workers visit pregnant women in their homes on a regular basis to check their blood pressure and blood sugar levels. A urine test is offered too. After the birth, the health worker visits the mother and baby to check the baby's weight, growth, development, and general health. The mother is also checked regularly by her health worker who provides education on women's health issues on a one-to-one basis. For more information visit <http://www.ntp.org.au/>

Jalaris Kids Future Club and Health Outreach Services, Western Australia

The Aboriginal Kids Future Club and Health Outreach Services in the Western Australian town of Derby work with about 105 families and their kids. At any one time they do intensive work with about six households, which can include up to 80 people.

The club aims to target vulnerable Aboriginal children most likely to miss out on education and health services and has already delivered positive results. Kids Future Club has exposed kids and their families to semi-structured learning and child development activities in preparation for school.

The club encourages a culture of learning using a literacy and numeracy approach. In the past truancy has been a major problem for Derby's Aboriginal families, so the club aims to increase by 30 per cent the number of Aboriginal children attending school. Meanwhile health practitioners pay a visit at least twice a year to each household with children enrolled in the club to promote healthy living and give them access to a mobile health clinic.

The Derby Aboriginal Health Service, Western Australia

The Derby Aboriginal Health Service (DAHS) opened its doors in 1998 after local Aboriginal people identified the need for an Aboriginal medical service. It provides clinical care, and preventative and health promotion services to the Derby region and eight remote communities.

DAHS has established a dedicated diabetes clinic with a focus on active recalling of patients, including known diabetics and other DAHS regular patients who are more than 12 months overdue for a diabetes screen. The service also provides diabetes education, GP assessment and management, monitoring of medicines, including insulin, and specific screening for people with diabetes, such as retinal screening.

The service has also taken measures to avoid 'over-specialising' in diabetes care, which can occur through de-skilling workers, missing opportunities to screen and care for people with diabetes who present to the clinic for other reasons, and missing opportunities to co-ordinate the approach to chronic disease in general. This has been achieved through ensuring that all workers spend time in the general clinic and encouraging the flow of work between the clinic and programs through regular meetings to nurture links between the programs. For more information visit http://www.kamsc.org.au/about_dahs.html



Caroline (the nurse in blue shirt) with a family in South Hedland. Caroline visits families in South and Port Hedland, as well as Strelley (an Aboriginal community about an hour from Port Hedland) to check on the health of the people living there. Caroline is a nurse with Wirraka Maya. Wirraka Maya is one of 19 Aboriginal Health Services in Western Australia that are part of the umbrella body Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO). WAACCHO is a partner of Oxfam Australia. *Photo: Jerry Galea/OxfamAUS*

5. SPECIFIC HEALTH INDICATORS

There is a greater disparity in disease-specific mortality rates between Indigenous and non-Indigenous populations in New Zealand and Australia compared with the USA and Canada.

The highest disease-specific mortality rates for heart disease and cancer are found in New Zealand. Canadian First Nation peoples have the highest mortality rates of all population groups for intentional self-harm and pneumonia/influenza. American Indians and Alaskan Natives have the highest mortality rates for all population groups for assault. Non-Indigenous Americans have the highest mortality rate for HIV and there is no difference in the rate of HIV between Australian Aboriginal and Torres Strait Islanders and non-Indigenous Australians.

TABLE II: General mortality – age-standardised mortality rates (per 100,000)³⁴

Disease	Australia			New Zealand			Canada			USA		
	I*	NI**	RR§	I*	NI**	RR§	I*	NI**	RR§	I*	NI**	RR§
Total neoplasms (tumors)	237.0	187.0	1.3	228.2	146.1	1.6	98.9	143.0	0.7	91.3	142.0	0.6
Ischaemic heart disease (includes angina and heart attacks)	162.6	87.1	1.9	206.1	110.2	1.9	83.8	89.6	0.9	83.1	118.9	0.7
Cerebrovascular disease (stroke)	73.8	35.5	2.1	55.2	47.2	1.2	28.1	30.9	0.9	25.3	35.6	0.7
Other chronic obstructive pulmonary disease (diseases of the lung and respiratory tract)	33.7	13.7	2.5	33.7	13.7	2.5	10.8	16.1	0.7	15.8	22.7	0.7
Intentional self harm	19.4	11.9	1.6	12.9	13.1	1.0	27.4	12.2	2.3	12.0	9.8	1.2
Pneumonia and influenza	13.2	6.2	2.1	9.9	10.3	1.0	24.4	17.7	1.4	14.0	13.2	1.1
Diabetes	85.4	8.7	9.8	62.5	11.0	5.7	19.5	13.3	1.5	36.2	16.7	2.2
HIV	3.8	3.8	1.0	1.0	0.5	2.0	NA	1.2	NA	2.9	5.0	0.6
Assault	7.8	1.4	5.6	3.9	1.0	3.9	8.1	1.5	5.4	10.6	6.4	1.7

*Indigenous, ** Non-Indigenous, § Relative risk

INFECTIONS

Australia

- Aboriginal and Torres Strait Islanders experience a greater burden of communicable and non-communicable infectious diseases compared to the non-Indigenous population³⁵
- Aboriginal and Torres Strait Islander children experience the highest rates of bacterial respiratory diseases reported in the literature.³⁶ The incidence of meningococcal infection among the Western Australian Aboriginal and Torres Strait Islander population is approximately six times that of the non-Indigenous population³⁷
- The prevalence of gastroenteritis among Western Australian Aboriginal and Torres Strait Islander infants and children is high and is a major cause of hospitalisation of infants³⁸
- The incidence of invasive pneumococcal disease is significantly higher in Aboriginal and Torres Strait Islanders compared with non-Indigenous Australians³⁹

New Zealand

- In New Zealand, the burden of disease due to infectious diseases continues to remain disproportionately high among Māori children and young people compared to European New Zealanders. A report on the health status of young children in New Zealand identified an increase in hospital admissions for bronchiolitis, bronchiectasis, gastroenteritis, and meningococcal infection particularly among Māori children in the most recent years. Hospital admissions for pneumonia remained static, although there was a higher rate of admissions among Māori people. Asthma admissions and deaths in young people have declined in New Zealand, although the rates of admission are higher for Māori young people⁴⁰

Canada

- In Canada, *Streptococcus pneumoniae* (pneumococcus) is the leading cause of invasive infections such as bacteraemia and meningitis. Despite advances in public health and medical care, chronic otitis media is still prevalent around the world, and continues to persist in Canada.⁴¹ This infectious disease and associated hearing loss has been reported as a frequent problem for many Inuit children.⁴² It has also been reported as endemic among First Nation, Métis and Inuit children in northern Canada⁴³

USA

- American Indians and Alaskan Natives have incurred excessive mortality and morbidity attributed to infectious disease for several decades.⁴⁴ In particular, American Indian/Alaskan Native infants are at much greater risk of death than non-Indigenous infants and have a higher mortality rate as a result of infectious disease⁴⁵
- While there has been a decline in infectious disease mortality among American Indian/Alaskan Natives over the past several decades, this population continues to have higher risks for infectious disease mortality than other groups
- Overall, infectious diseases are the third leading cause of death in the USA, and continue to be an important health issue⁴⁶

ISCHAEMIC HEART DISEASE (INCLUDES ANGINA AND HEART ATTACKS)

Australia

- Traditionally, Aboriginal people have been thought to have lower prevalence of cardiovascular disease (CVD) including ischaemic heart disease, but significant social economic and cultural change over the past several decades has negatively affected this. In the colonised nations, deaths due to CVD have been declining in the general population. However, it appears that such deaths among Indigenous populations have been increasing over the past decades
- In Australia, Kirov *et. al.* report that CVD is a leading cause of premature death and death overall in Aboriginal and Torres Strait Islanders and non-Indigenous Australians. However, the disparity between these two populations is increasing due to the lack of significant reduction in CVD-related deaths among Aboriginal and Torres Strait Islanders
- The failure to substantially reduce CVD among Aboriginal and Torres Strait Islanders probably reflects a combination of little change in risk factors levels, access to treatment and rehabilitation services, persisting social, economic and environmental circumstances, and the slow implementation of strategies to reduce levels of CVD⁴⁷

New Zealand

- Māori men and women continue to experience more than double the CVD mortality rates of Europeans.⁴⁸ The death rates due to CVD for people under 75 years are two to three times higher in Māori people compared to non-Māori people. In the Māori population 53 per cent of the male deaths and 33 per cent of the female deaths occur before the age of 65 years.⁴⁹ Riddell reported mortality and hospitalisation rates for heart failure up to eight times higher among Māori people compared to non-Māori people aged 45–64 years⁵⁰

Canada

- The prevalence of CVD, while declining among all Canadians, has been reported to be increasing among Canadian Aboriginal people. A study by Anand *et. al.* reported a higher frequency of CVD among Aboriginal people in Canada and a greater burden of atherosclerosis compared with Canadians of European ancestry⁵¹ As observed among other Indigenous people of the world, Canadian Aboriginal people have traditionally been thought to have a lower prevalence of CVD. However, as with other colonised people there has been significant social, economic and cultural changes in the past several decades which has impacted on an observed increase in cardiovascular related disease⁵²

USA

- While available data now indicate that cardiovascular disease has become the leading cause of death in American Indians, limited information is available on cardiovascular disease incidence, prevalence, and risk factors in this population. Reported cardiovascular disease rates vary greatly among groups in different geographic areas. Available rates have been obtained from studies of varying sizes and different methodologies
- A study by Howard *et.al.* reported that at present, coronary heart disease (CHD) rates in American Indians exceed rates in other US populations and may more often be fatal. Unlike other ethnic groups, American Indians appear to have an increasing incidence of CHD, possibly related to the high prevalence of diabetes⁵³

INJURIES

Rates of injuries are known to be higher among Indigenous peoples in North America, Australia and New Zealand compared to non-Indigenous people in those countries.⁵⁴

Australia

- In Australia, injury is the leading cause of death, illness and disability, representing about six per cent of all deaths and accounting for seven per cent of hospital admissions in the general population⁵⁵
- Available evidence suggests that the overall injury mortality rate in the Northern Territory, Western Australia, South Australia and Queensland was 2.8 times higher among Aboriginal and Torres Strait Islanders compared with all Australians in these jurisdictions. Further, injury rates were generally higher among Aboriginal and Torres Strait Islander males than females⁵⁶
- Harrison *et.al.* report that the rates of injury mortality and hospital admission due to injury are substantially higher for Aboriginal and Torres Strait Islanders than for the Australian population as a whole. Cunningham *et. al.* report that the analysis of available data shows the injury-related mortality experience for Aboriginal and Torres Strait Islanders differs substantially from that of the non-Indigenous population⁵⁷
- The Australian Institute of Health and Welfare reported higher injury-related morbidity and mortality rates for Aboriginal and Torres Strait Islanders in remote areas, probably due to the increased proportion of Aboriginal and Torres Strait Islanders in remote areas with limited access to health and other services⁵⁸
- Road injury is a major public health problem and is particularly the case for road injuries involving Aboriginal and Torres Strait Islanders in Western Australia who have much higher rates of road injury compared with non-Indigenous Australians⁵⁹

New Zealand

- Māori youth had particularly high rates of motor vehicle occupant and self-inflicted injury and were over-represented among hospitalisations for assault and pedestrian injury.⁶⁰ Sargent *et. al.* report that motor vehicle traffic crashes were the leading cause of injury mortality and hospitalisation among Māori people, particularly among young Māoris⁶¹

Canada

- Aboriginal Canadians were at a four-fold increased risk of severe trauma compared with the non-Aboriginal population with motor vehicle crashes accounting for the overwhelming majority of cases of severe injury or death in both populations. Further, Aboriginal Canadians were almost five times more likely to be involved in motor vehicle crashes compared with all Canadians (Karmeli 2005 *opcit.*)

USA

- Injuries account for 75 per cent of all deaths among American Indian and Alaskan Native children and youth and American Indians/Alaskan Natives have an overall injury-related death rate that is twice that for all racial/ethnic populations⁶²

RENAL

In many Aboriginal communities, the burden of kidney disease, particularly the multi-generational occurrence in some families, is perceived as a major threat to the wellbeing of Aboriginal communities.

Australia

- The high rates of renal disease and renal failure are a serious public health threat to Aboriginal and Torres Strait Islanders, but the high rates of end-stage renal disease (ESRD) within this population have only been fully recognised in recent years⁶³
- Information on the incidence and prevalence of chronic kidney disease (CKD) among Aboriginal and Torres Strait Islanders is not available at a national level. Compared with other Australians, Aboriginal and Torres Strait Islanders, in particular those in remote communities, have excessive CKD morbidity.⁶⁴ Spencer *et. al.* reported the doubling of ESRD incidence among Aboriginal people in the year 2000
- These increasing rates of kidney disease have major medical and social implications for Aboriginal and Torres Strait Islanders including the impact of premature mortality on the community; the negative social consequences that accompany treatment; and the high cost of tertiary-level medical care that adds an enormous burden to limited resources. Better living conditions and education, robust and integrated primary healthcare programs, and systematic screening for early renal disease and treatment of those with established disease are all matters of urgency⁶⁵



Michelle Spinks working on her artwork while on dialysis machine at the Port Hedland hospital. Wirraka Maya is one of 19 Aboriginal Health Services in Western Australia that are part of the umbrella body Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO). WAACCHO is a partner of Oxfam Australia.
Photo: Jerry Galea/OxfamAUS

New Zealand

- The number of Indigenous people treated with renal replacement therapy (RRT) and end-stage renal disease (ESRD) in Australia and New Zealand has risen dramatically over the past 20 years.⁶⁶ It is now a major health problem for the individuals affected as well as the local communities and health services providers

Canada

- In a Canadian study of ten-year incidence rates of diabetic end-stage renal disease, results showed a higher rate among all age groups of registered native people compared with non-native people. When a higher prevalence of diabetes among native people was taken into account, native diabetic people were still seven times as likely as non-native diabetic people to manifest diabetic end-stage renal disease⁶⁷

USA

- Narva reports that native Americans experience high rates of end-stage renal disease and that these rates are increasing significantly.⁶⁸ Narva also reports that the burden of ESRD has become a community-wide problem, and that significant efforts have gone into establishing dialysis services on reservations (Narva *ibid*)

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Australia

Australia has so far prevented the uncontrolled spread of HIV among its population and the number of cases of HIV and AIDS cases in Australia are among the lowest in the world⁶⁹

- However, great concerns have been expressed about the possible impact of HIV/AIDS among Aboriginal and Torres Strait Islanders, for whom AIDS was seen as having the potential to “further erode the social and economic fabric of Indigenous communities.”⁷⁰ Aboriginal and Torres Strait Islanders are seen as being at a particularly high risk of contracting HIV infection due to the high rates of sexually transmitted infections and lack of access to effective services⁷¹
- The Australian Indigenous HealthInfoNet reports that by the end of 2004, the cumulative number of HIV diagnoses was estimated to be 19,674 with an estimated 13,20 people living with HIV/AIDS infection,⁷² a rate of 3.8/100,000
- A number of features in the HIV epidemic distinguish Indigenous from non-Indigenous cases including a higher proportion of women affected, a higher proportion with heterosexual exposure to HIV, a younger age at HIV and AIDS diagnosis and a higher proportion of people with HIV in rural areas.⁷³ Wright *et. al.* report that while the rate of HIV infection declined among non-Indigenous Western Australians between 1985 and 2002, the rate increased among the Aboriginal and Torres Strait Islander population⁷⁴ and thus the rate of HIV became the same among both populations

New Zealand

- New Zealand has a low annual incidence of new HIV infections and subsequent low mortality rates among Māori people as reflected in study findings. The New Zealand response to the HIV epidemic has been viewed as a public health success story⁷⁵

Canada

- In a population-based analysis of Aboriginal British Columbians affected with HIV, Hogg *et. al.* reported that more than one in every 100 Aboriginal persons aged 15 years and over was living with HIV in 2001. Further, approximately a quarter to a third of all infections among Aboriginal people in Canada occurred in British Columbia⁷⁶

USA

- The Centers for Diseases Control and Prevention reported that from the start of the epidemic through to 2002, there were 2,875 reported AIDS cases among Native Americans in the USA.⁷⁷ Although HIV infection in the American Indian/Alaskan Native population remains less than 1 per cent of the total HIV infection rate in the USA, the true prevalence is not known due to low rates of testing and misclassification (HRSA 2004 idem)

PULMONARY DISEASE (DISEASES OF THE LUNG AND RESPIRATORY TRACT)

Australia

- In Australia, respiratory diseases are the major causes of illness and death in the Aboriginal and Torres Strait Islander population and have contributed to high rates of hospitalisation since at least the 1980s⁷⁸ and deaths from respiratory illness continue to be an important, ongoing health problem in Australian Aboriginal communities⁷⁹
- Aboriginal and Torres Strait Islanders suffer pulmonary disease at more than three times the rate of Indigenous peoples in Canada and more than twice the rate of Indigenous peoples in the USA
- Further, the prevalence of respiratory syncytial virus (RSV), the most common cause of lower respiratory tract infection (LRTI), is much higher in Aboriginal and Torres Strait Islander children than in non-Indigenous children⁸⁰
- Aboriginal and Torres Strait Islanders reported asthma as a long-term condition more often than the non-Indigenous population (17 per cent and 12 per cent respectively). Aboriginal and Torres Strait Islanders living in remote areas reported having asthma slightly less frequently (15 per cent) than those in urban and rural areas (18 per cent)⁸¹
- In addition to medical reasons, factors contributing to respiratory diseases include socio-economic disadvantage, poor environmental living conditions, substantial poverty and a lack of basic health services⁸²
- Read *et. al.*, using total population linked data, reported a higher hospitalisation and readmission rate for LRTI in Aboriginal and Torres Strait Islander children compared with non-Indigenous children.⁸³ In a more recent study, Burgner *et. al.*, using similar population data, reported that Aboriginal and Torres Strait Islander children in Western Australian had a 10–12 fold higher risk of pneumonia-associated hospitalisation compared with non-Indigenous children⁸⁴

New Zealand

- In New Zealand, studies report higher rates of hospitalisation due to pneumonia⁸⁵, asthma⁸⁶ and bronchiectasis⁸⁷ among Māori children when compared with European children

Canada

- The Royal Commission on Aboriginal Peoples of Canada reports that more than 19 per cent of Aboriginal people aged more than 15 years reported having chronic health problems of asthma, bronchitis and emphysema.⁸⁸ This rate is much higher than reported previously indicating that asthma and chronic obstructive pulmonary disease (COPD) may be increasing at a faster rate in the Aboriginal community compared with the non-Aboriginal community⁸⁹

USA

- Because of the association between bronchiolitis and respiratory syncytial virus (RSV), the most common cause of lower respiratory tract infection, bronchiolitis is a good indicator of RSV. Rates of bronchiolitis-related hospitalisation for American Indian/Alaskan Native children are approximately twice that for the general population of US children⁹⁰

DIABETES

Diabetes is a powerful determinant of health outcome and for Indigenous peoples across the four countries, diabetes-related mortality is high (see Table II).⁹¹

Diabetes is a chronic disease with multifactorial causes involving the interactions of genetic susceptibility with environmental factors. Young *et. al.* suggested that: “diabetes [can] be considered to be indicative of the rapid social changes experienced by Aboriginal people in the past several decades.”

Australia

- Diabetes has been also been reported as being a significant and increasing health issue among Indigenous people. Australian Aboriginal and Torres Strait Islanders, in particular have a high mortality rates associated with diabetes – the Indigenous/ non-Indigenous relative difference of 9.8 was the highest reported.
- Daniel *et. al.* state that: “type 2 diabetes and its sequelae, such as cardio-vascular disease and renal diseases, are the major causes of premature mortality among Aboriginal Australians”.⁹²

New Zealand

- Moore *et. al.* reported that New Zealand faced an escalating burden of diabetes and its complications, particularly in relation to end-stage renal failure. They also reported that the burden of renal failure was “especially high in Māori and Pacific Islanders” and that “this related to both their higher incidence of Type 2 diabetes and an apparent increased susceptibility to end stage damage.”⁹³

USA

- Moore *et. al.* reported that Type 2 diabetes was increasing among young American Indians and other populations.⁹⁴ Lee *et. al.* reported that Type 2 diabetes had reached epidemic proportions in many American tribes and was the leading cause of mortality and morbidity in these populations⁹⁵
- Among Indigenous people living in the USA, over the past decades the disease burden among the American Indian and Alaskan Native population has shifted from acute infectious diseases to chronic illnesses, particularly Type 2 diabetes and its complications. Narva reports that diabetes, a condition virtually unknown prior to World War II has “reached epidemic proportions among the native population of North America.”⁹⁶



Health Care Worker conducts an eye examination at Wirraka Maya Aboriginal Medical Service in Port Hedland, Western Australia. Wirraka Maya is one of 19 Aboriginal Health Services in Western Australia that are part of the umbrella body Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO). WAACCHO is a partner of Oxfam Australia.

Photo: Jerry Galea/OxfamAUS

GLOSSARY

ACCHS	Aboriginal Community Controlled Health Services
AIDS	Acquired Immune Deficiency Syndrome
AIHW	The Australian Institute of Health and Welfare
AMA	Australian Medical Association
ARF	acute rheumatic fever
ATHS	Alaska Tribal Health system
CKD	chronic kidney disease
CHD	coronary heart disease
COPD	chronic obstructive pulmonary disease
CVD	cardio vascular disease
ESRD	end-stage renal disease
FNIHB	First Nations and Inuit Health Branch
HREOC	Human Rights and Equal Opportunity Commission
HIV	Human Immunodeficiency Virus
IHD	Ischemic heart disease
LRTI	lower respiratory tract infection
NACCHO	National Aboriginal Controlled Community Health Organisation
NCHECR	National Centre in HIV Epidemiology and Clinical Research
RHD	rheumatic heart disease
RRT	renal replacement therapy
RSV	respiratory syncytial virus
STIs	Sexually transmitted infections
VPDs	vaccine preventable diseases

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